

Maintaining an Operational U.S. Army Reserve through Medical Readiness

by

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United States Army War College
Class of 2012

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REPORT DOCUMENTATION PAGE				<i>Form Approved</i> OMB No. 0704-0188	
Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0188), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.					
1. REPORT DATE (DD-MM-YYYY) 07-03-2012		2. REPORT TYPE Strategy Research Project		3. DATES COVERED (From - To)	
4. TITLE AND SUBTITLE Maintaining an Operational U.S. Army Reserve through Medical Readiness				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S) Lieutenant Colonel Todd M Lazaroski				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Dr. James E. Gordon Department of Military Strategy, Planning, & Operations				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES) U.S. Army War College 122 Forbes Avenue Carlisle, PA 17013				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION / AVAILABILITY STATEMENT Distribution: A					
13. SUPPLEMENTARY NOTES					
14. ABSTRACT Our nation is currently reflecting upon the last decade of commitment our forces have made in meeting operational requirements in Iraq and Afghanistan. In the past ten years, the USAR has not met medical readiness goals set by the DoD. This paper examines the current USAR medical readiness process and its ability to sustain an Operational Reserve. This analysis compares the performance of current processes against DoD requirements and the USAR medical metrics. Based on this analysis, this paper will recommend changes or improvements to the USAR medical readiness process as an Operational Reserve.					
15. SUBJECT TERMS Reserve Health, ARFORGEN, Strategic USAR					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT UNLIMITED	18. NUMBER OF PAGES 36	19a. NAME OF RESPONSIBLE PERSON
a. REPORT UNCLASSIFIED	b. ABSTRACT UNCLASSIFIED	c. THIS PAGE UNCLASSIFIED			19b. TELEPHONE NUMBER (include area code)

USAWC STRATEGY RESEARCH PROJECT

MAINTAINING AN OPERATIONAL U.S. ARMY RESERVE THROUGH MEDICAL READINESS

by

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ABSTRACT

AUTHOR: Lieutenant Colonel Todd M Lazaroski

TITLE: Maintaining an Operational U.S. Army Reserve through Medical Readiness

FORMAT: Strategy Research Project

DATE: 7 March 2012 WORD COUNT: 7,188 PAGES: 36

KEY TERMS: Reserve Health, ARFORGEN, Strategic USAR

CLASSIFICATION: Unclassified

Our nation is currently reflecting upon the last decade of commitment our forces have made in meeting operational requirements in Iraq and Afghanistan. In the past ten years, the USAR has not met medical readiness goals set by the DoD. This paper examines the current USAR medical readiness process and its ability to sustain an Operational Reserve. This analysis compares the performance of current processes against DoD requirements and the USAR medical metrics. Based on this analysis, this paper will recommend changes or improvements to the USAR medical readiness process as an Operational Reserve.

MAINTAINING AN OPERATIONAL U.S. ARMY RESERVE THROUGH MEDICAL READINESS

As an enduring operational force, the Army Reserve is the premier force provider of America's Citizen-Soldiers for planned and emerging missions at home and abroad. Enhanced by civilian skills that serve as a force multiplier, we deliver vital military capabilities essential to the Total Force.

—Chief Army Reserve, &
Commanding General, US Army Reserve
Command 28 January 2011

The past ten years of operational tempo has changed the USAR in many ways. Arguably, the most significant of these changes is the transition from a legacy strategic reserve to an operational reserve. Much has been written on the adaptation or metamorphosis from a strategic to an operational force. The new and growing concern is how this newly minted operational reserve will maintain its readiness in support of the active component. Operational demands during the past decade have surpassed any other operational requirements in the history of the United States Army Reserve (USAR). After the Gulf war ended in 1990, the active army began a review of reserve assets in greater depth for operational support. However, due to draw downs, diminishment of the communist threat and economic factors the idea of transforming the reserve component to an operational reserve never saw fruition; until 9-11. Post 9-11 operational requirements by the active military highlighted the demand for a more robust, dynamic, operational reserve to support the highly tasked expeditionary active component. In response, the Army Reserve recast itself from the part time strategic reserve role to a fully integrated and critical part of an operational, expeditionary Army that supports the nation's evolving and challenging wartime requirements.¹ More than

196,711 Army Reserve Soldiers have been mobilized in support of Operation Iraqi Freedom/New Dawn and Operation Enduring Freedom since September 11, 2001.² As the USAR transformed from a strategic to an operational force, there was a need to formerly model how that process would evolve and be maintained. The resulting model was the Army Forces Generation Model commonly known as ARFORGEN. In 2005 the now widely known Army Forces Generation model (ARFORGEN) was accepted by the Army Chief of Staff to provide a structured, sustainable model in providing soldiers to two theaters of operations. “Under ARFORGEN, unit readiness is managed on a cyclical basis, with [reserve component] units ready for deployment one year out of five as a planning target.”³ If the USAR did not have an identified, legitimate basis to transform to an operational reserve prior to 2005, ARFORGEN certainly provided it. This model would provide a basis for the USAR to ensure that soldiers would be able to meet medical readiness standards in order to meet the rotational requirements of the active component and national security strategy. A critical piece of readiness for any unit is medical readiness. To date, the USAR has not met the mandated DoD requirements of 80% for medical readiness. This paper intends to focus on the active USAR force (excluding the Individual Ready Reserve or IRR) and analyze those processes that will be required to bring and maintain medical readiness for an operational reserve.

Historical Medical Metrics and Trends

There are two specific terms that define medical readiness rates in the USAR. The first is Fully Medical Ready (FMR) and the other is Medical Readiness Classification (MR). FMR is being replaced by the later MR as the term used to describe overall medical readiness. Essentially FMR and MR are the same metric. The

MR indicator has several components; Pregnancy (PRG), Medically Nondeployable (MND), DNA on File (DNA), Dental Readiness Classification (DRC), HIV test (HIV), Immunizations current (IMM), Limited Duty Profile (LDP) , and Periodic Health Assessment (PHA). Figure 1 below is taken from the 2011 Medical Readiness Leaders Guide and explains in more details how these deficiencies are tracked.

Medical Readiness Categories	Deficiencies	Availability
MR 1 – Meets all requirements	None	Available
MR 2 – IMR requirements that can be resolved within 72 hours	Immunizations Dental Class 2 conditions Medical warning tags DNA (Deoxyribonucleic Acid) test HIV (Human Immunodeficiency Virus) test	Available
MR 3A - IMR requirements that can be resolved within 30 days. Includes deficiencies that would be resourced for correction for alerted RC Soldiers	Dental Class 3 condition Temporary profile less than 30 days	Non-Available
MR 3B - IMR requirements that cannot be resolved in 30 days	Pregnancy Permanent profile pending board action Temporary profile greater than 30 days	Non-Available
MR 4 – The current status is not known	Missing or incomplete current Periodic Health Assessment Missing or incomplete current dental screening	Available

Figure 1: USAR Medical Readiness Categories, Deficiencies and Availability⁴

The MR is calculated by subtracting out (from the given unit of soldiers) those who haven't had a PHA, then those who are not dentally ready and then those who have a profile.⁵ MR is listed as the percent of soldiers that meet all of the indicators satisfactorily and are deployment ready. Any area that is not met will place the soldier in a non-deployable status and thus count against the MR composite score. For

instance, medically non deployable may have a permanent physical condition that allows the soldier to stay in uniform; however, their condition prevents them from deploying in theater.

The goal for achieving MR is constantly incrementally increasing. In the years 2007 to 2010, the MR has been set at 75%. The Office of the Under Secretary of Defense (OUSD) for Personnel and Readiness Strategic Plan for Fiscal Years 2010-12 call for 80% MR by the end of 2010.⁶ It is not exactly clear what formula is used to develop the MR goals, however, the goals apply equally to the active and reserve components. As of this writing the following goals apply to each sub measure of the MR: DNA, 100% on file, HIV test 100% on file, Immunizations 90%, PHA 90%, and Dental is 95%.⁷

Prior to October 2006, USAR Soldiers were required to complete a physical every five years. Tracking mechanisms, command emphasis and measurement for success were ill defined. The only published standard available prior to 2001, Army regulation 40-501, Standards of Medical Fitness, paid scant attention to the codification of deployment health and what could be deemed “success.”⁸ As recently as 2008, the overall medical readiness rate of the USAR was 24% and is currently hovering around 60% as of April 2011 (see figure 2). As the USAR began to evolve into an operational force, the requirement for medical readiness became paramount to success in theater and a new system of measurement and tracking needed to be created in order to manage the health of the force. The USAR needed to align operationally with the active component and having a medically ready force was a key to successfully meeting that requirement.

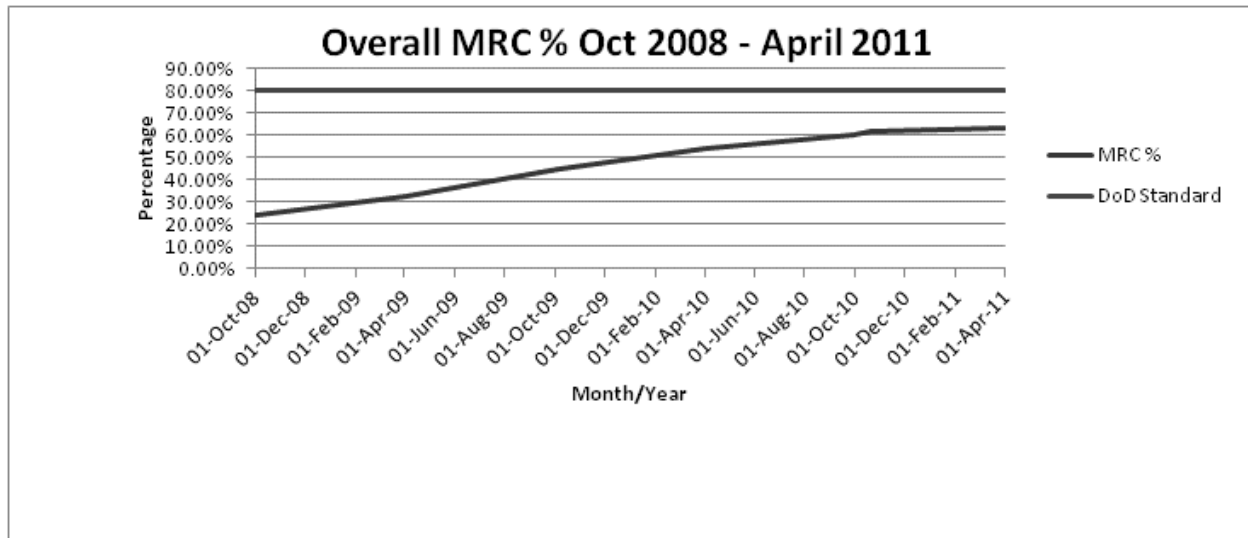


Figure 2: Overall MRC from October 2008 to April 2011.⁹

Operational Direction of the USAR

Gen. David M. Rodriguez, FORSCOM commander recently commented: “We cannot afford to squander the decade of operational experience resident in the Army National Guard and Army Reserve today.”¹⁰ In the summer of 2011, the United States Army Reserve Command moved from Ft. McPherson, Georgia to Ft. Bragg NC and is collocated with FORSCOM in a state of the art facility. It may be coincidental or intentional that the active and reserve commands are sharing the same office space, however, the active component recognizes the fact that the Army Reserve is a critical component to their war fighting capability. “Today’s Army reserve is uniquely positioned and structured to provide operational support in complex security environments. Army requirements can be met for combat support or combat service support roles....The ability to mobilize quickly and responsively makes the Army Reserve ideally suited to meet the nation’s future requirements.”¹¹

As of this writing there is no known AC strategy published for the USAR, however, both the reserve and active components recognize that reverting back to a

strategic reserve will not provide the active component with the support from the reserve in a quick and responsive manner. In support of promoting and sustaining an operational reserve force the active component has formally identified medical readiness as an issue that must be addressed. In May of 2011, the United States Army Medical Command (MEDCOM) instituted the Soldier Medical Readiness Campaign Plan (SMR-CP). The purpose of this campaign is to improve the medical readiness of the Army.¹²

As a further testament to the commitment of the active army in keeping the reserves ready and operational, the SMR-CP provides a joint active/reserve command structure. The U.S. Army Surgeon General has appointed the Deputy Surgeon General for Mobilization, Readiness and Reserve Affairs, MG Richard A. Stone as the campaign lead.¹³ The campaign plan seeks to improve the medical readiness of the Army through three primary lines of effort (LOE): LOE 1.0 Medically Not Ready (MNR) Soldier Identification; LOE 2.0 MNR Management Programs; and LOE 3.0 Evidence-Based Health Promotion, Injury Prevention, and Human Performance Optimization Programs.¹⁴ MEDCOM's mission is to execute a coordinated, synchronized, and integrated comprehensive SMR-CP to support Army Force Generation (ARFORGEN) in each of its phases to increase medical readiness of the Army.¹⁵

There are two very specific sub components of the SMR-CP plan that address USAR readiness, these are housed under LOE 2.0: 2.2 Establish Reserve Component Soldier Medical Support Center and 2.3 Improve Reserve Health Readiness Program.¹⁶ Both of these components support the handling of MNR reserve soldiers and appear to

enhance or improve out dated or ineffective current processes. The SMR-CP describes LOE 2.2 as:

The Reserve Component-Soldier Medical Support Center (RC-SMSC) is a Vice Chief of Staff of the Army (VCSA) directed activity that will ensure standardization of medical processing of MNR Reserve Component Soldiers to either Return to Duty (RTD) or be referred to the Physical Disability Evaluation (PDES)....The desired end state of this initiative is the reduction of Medically Non ready (MNR) Soldiers with permanent (P3/P4) profiles through review and validation of profiles or return to duty, and ensuring standardized and timely Medical Evaluation Board (MEB) entry and adjudication of Soldiers with disqualifying medical issues.¹⁷

LOE 2.3 Improve Reserve Health Readiness Programs, essentially provides greater oversight and management of the Reserve Health Readiness Program (RHRP). The purpose of this objective is to ensure that we adequately measure the value added to all of the efforts aimed at identifying, tracking and managing funds expended by the Army RC individual medical readiness.¹⁸ The basis for refining this measurement system is to understand how to better allocate resources to the reserve component in an effort to meet medical readiness standards. Unlike the active component, the reserve component does not fully benefit from active duty treatment facilities for its members. The lack of benefit reasons include; geographic distance from an RC soldiers home to an active military medical center, the ability of active medical facilities to support increased numbers of RC soldiers in addition to the AC requirement, and hours or availability for RC soldiers who work or are in school. Through this analysis [LOE 2.3], determines the best course solution from possible courses of action such as: the RC continues to utilize the Office of the Assistant Secretary of Defense/Health Affairs (OASD/HA) provided contract vehicle, other contract options, or use internal resources.¹⁹

Chief of the USAR: 2011 Strategic Vision and Directives

The Chief of the US Army Reserve (CAR) has provided what may be the most descript, comprehensive and pointed posture statement for the USAR in recent memory. The CAR, like the FORSCOM commander and other high ranking Army leaders recognize that the future of the USAR is vital to the security of this country. The CAR has outlined the following priorities in the USAR 2011 Posture Statement.²⁰

- a. Continue to transform to an enduring operational force
- b. Continue to provide the best trained, best led, best equipped Soldiers and units to combatant commanders to achieve US objectives and ensure national security
- c. Recruit, retain and reintegrate through Continuum of Service the best and brightest Citizen-Soldiers to sustain a robust and capable operational Army Reserve
- d. Provide Citizen-soldiers and their families with the training, support and recognition to sustain a cohesive, effective fighting force
- e. Build and maintain a partnership with industry to facilitate Citizen-Soldier contributions to both a prosperous economy and a skilled, experienced and capable Army

Illustrated in the Army Reserve 2020 Vision and Strategy document, the USAR force will be divided into four groups across the five year ARFORGEN model as seen in Figure 3.

As illustrated in Figure 3, from the 205k pool of USAR members, the current commitment of reserve forces to the active component is 24k troops annually. This pool of 24k soldiers is sourced from a rotational force of 120k members. Thus, the USAR will need to have 24K troops prepared for active service on an annual basis and be fully MR at a minimum.

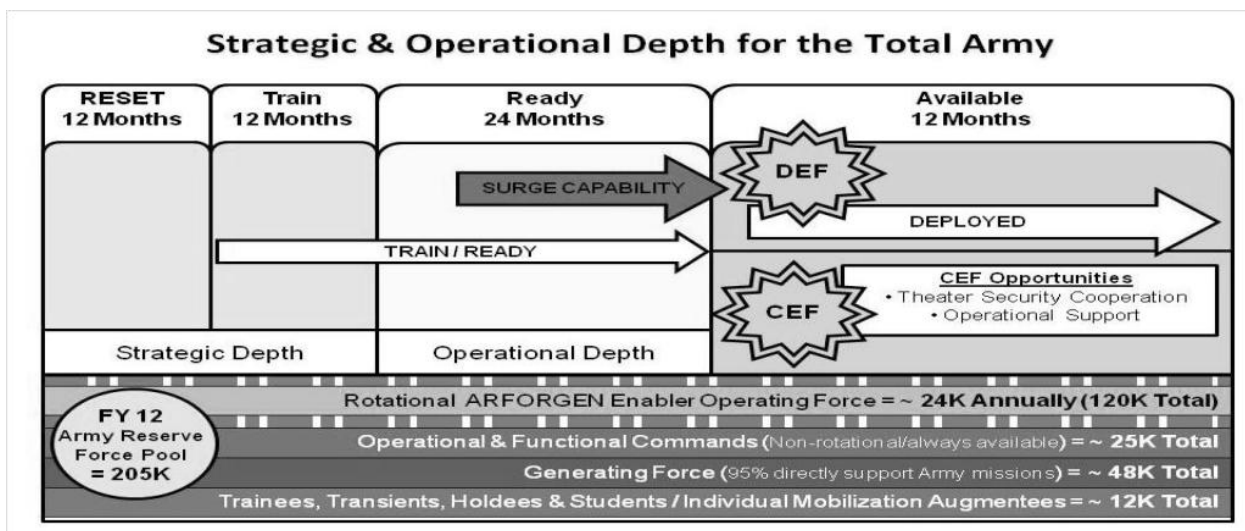


Figure 3: Strategic and Operational Depth for the Total Army ²¹

DoD Directives

It should be no surprise that the DoD recognizes medical readiness as a vital piece of Strategic Readiness. Statute 10 USC 10206 calls for an annual physical and medical readiness levels to be reported to the Secretary of Defense by all U.S. military reserve components. Secretary of Defense Robert Gates recognized the need to maintain an operational reserve with a formal directive in 2008. Contained within DoDD 1200.17: Managing the Reserve Components as an Operational Force are several sub directives:

- a. Ensure policies are in place to support medical and dental readiness such that RC members comply with required medical and dental standards pre-activation through deactivation.²²
- b. Ensure policies are in place to provide RC members and their families' appropriate medical, dental and mental health services consistent with DoD programs to provide support to America's wounded, ill, and injured Service members.²³
- c. Ensure that resources support medical and dental readiness such that RC members comply with required medical and dental standards pre-activation through deactivation.²⁴

As early as 2006, specific goals on how an operational reserve translates to medical readiness were identified by the DoDI 6025.19: Individual Medical Readiness; "The minimum goal for overall medical readiness is more than 75% of Service Members FMR (Fully Medical Ready), with the ideal being 100%."²⁵ However, since the publication of DoDI 6025.19, the OSD Strategic Plan for 2010-2012 calls for an 80% MR.²⁶ The office of the Undersecretary of Defense for Personnel and Readiness has recognized medical readiness as an important aspect to force readiness. In the Fiscal Year 2012-2016 Strategic Plan, the Undersecretary calls out some very specific guidelines to ensure the health of our force. Accordingly, the goals and actions in this plan are structured around three fundamental focus areas- Total Force Readiness, Care for Our People, and creating and sustaining a culture of Relevance, Effectiveness and Efficiency.²⁷ The fundamental focus area of Total Force Readiness houses the medical readiness

component. Under the Care for Our People focus area the Under Secretary spells out: “promoting healthy behaviors and improving access to quality healthcare at an affordable cost”.²⁸

In support of the three focus areas mentioned above, the Under Secretary of Defense has also outlined several strategic goals. Strategic Goal 3 spells out addressing medical readiness specifically:

Strategic Goal 3- Deliver quality healthcare at an affordable cost while improving medical readiness. This goal emphasizes medical and dental readiness (Active and Reserve components and the civilian expeditionary workforce), promoting physical and mental wellness of the Total Force, and delivering accessible, quality healthcare at a reasonable cost with a benefit that is portable. Successful attainment of this goal will be evident when the Active and Reserve components are medically ready for deployment. Also, the Military Health Systems will provide an overall quality healthcare experience leading to reduced generators of ill health by encouraging healthy behaviors, thereby decreasing the likelihood of illness through focused prevention and the development of increased resiliency. Success in this goal will also be evident when the Military Health System per capita costs increase at a rate of one percent less than civilian health insurance increases.²⁹

Current Metrics and Performance

The last ten years have been transformational to say the least for the USAR. Prior to 2006, the USAR was required to complete a physical every five years. Before 2006 and USC 10206, medical readiness was not the priority for units to be combat ready and early medical readiness figures support this. Currently, there are eight key areas that are measured in the U.S. Army Medical Protection System (MEDPROS) to compile the overall Medical Readiness Classification (MR) and they are Pregnancy (PRG), Medically Non Deployable (MND), DNA on file (DNA), Dental Readiness (DRC), HIV test (HIV), Immunizations (IMM), Limited Duty Profile (LDP) and Periodic Health Assessment (PHA).

The original USAR MR goal was 75% as described in DoD Directive 6025.19: Individual Medical Readiness, but has been increased to 80% according to the Office of the Under Secretary of Defense for Personnel and Readiness Strategic Plan for Fiscal Years 2010-2012. The following six Individual Medical Readiness Key Element Standards are addressed in the DoDI 6025.19, dated January 3, 2006.³⁰

E3.1.1. Dental Readiness. All Services use the same classification system to assess and monitor dental readiness. **Pass:** Class 1 or 2 per current annual dental exam. **Fail:** Dental Class 3 or 4. The class is 4 when the annual exam is overdue. For this purpose, an exam is overdue if it is not accomplished within three months following the due month. Example: a dental exam due last accomplished in October 2005 will be counted as overdue if it has not been accomplished by the last day of January 2006.

E3.1.2. Immunization Status. Immunizations effectively prevent infectious diseases in the deployed as well as non-deployed environments. Immunizations will be monitored and kept current. **Pass:** Current for Total Force/All Services vaccines including hepatitis A, tetanus-diphtheria (Td), MMR, IPV, hepatitis B (if series began) and influenza (once per season). **Fail:** overdue for one or more vaccines. Vaccinations are overdue 30 days after their scheduled due date. There is a special rule for influenza, which usually becomes available in October of each calendar year. An influenza vaccination is overdue if not administered by January 1 of the current flu season. There are exceptions to vaccination requirements per Military Department or Service policy and occupational or deployment considerations (including medical and administrative reasons). Special immunizations, sometimes referred to as “flagged” vaccines are those required for one’s occupation (e.g., rabies, typhoid, hepatitis B, etc.) or specific for a planned operation due to location or threat (e.g., anthrax, smallpox, Japanese encephalitis, yellow fever, etc.). While important, these will not be assessed as part of the DoD IMR report until such time as all Services have the ability to consistently track and report these types of immunizations. Services with such capability are strongly encouraged to monitor “flagged” immunizations internally.

E3.1.3. Individual Medical Equipment. Medical equipment will be monitored as appropriate for personnel subject to deployment. The core requirement is one pair of gas mask inserts (GMI) for all deployable assets needing visual correction. Service-specific policies may identify additional items of medical equipment, such as two pair of prescription spectacles, hearing aid batteries, etc., but they are not part of the DoD core-reporting element. **Pass:** one pair of GMI for all deployable personnel needing

visual correction. **Fail:** no GMI for all deployable personnel needing visual correction.

E3.1.4. Medical Readiness Laboratory Studies. Core studies for the Department of Defense are current HIV testing and a DNA sample on file in the Armed Forces Repository of Specimen Samples for the Identification of Remains (AFRSSIR). Military Department or Service-specific policies may identify additional readiness lab tests such as Glucose-6-phosphate dehydrogenase or hemoglobin S (sickle) testing, but they are not part of the DoD core-reporting element. For core reporting elements: **Pass:** HIV testing, with result on file, within past 24 months, and DNA sample on file with the AFRSSIR. **Fail:** one or more deficiencies.

E3.1.5. No Deployment Limiting Conditions. There are many examples of deployment-limiting conditions such as pregnancy, asthma, severe traumatic injury with incomplete rehabilitation, etc. Deployment limiting conditions are defined by Military Department-specific policies. **Pass:** there are no deployment limiting conditions. **Fail:** there is a deployment limiting condition.

E3.1.6. Periodic Health Assessments (PHA). An Annual assessment for changes in health status, especially changes that could impact a member's ability to perform military duties. Military Department-specific requirements for currency and methodology of periodic health assessment have been defined. **Pass:** annual PHA is current. **Fail:** annual PHA is overdue. For this purpose the PHA is overdue if not accomplished within three months following the due month. Example: a PHA due in October 2005 will be counted as overdue if it has not been accomplished by the last day of January 2006.

Although there are eight areas measured in MEDPROS for MR, the eight areas fit into those six elements listed above. Dental, PHA, Immunizations are stand alone, HIV and DNA fit into the Medical Readiness Laboratory Studies, the other three which include pregnancy, MND and LDP are rolled into the No Deployment Limiting Conditions segment. The obvious goal for each of these areas is 100% and thus being 100% MR compliant. However, 100% may be a far reach as soldiers will get sick, pregnant and require routine medical and dental maintenance. Percent compliant for dental readiness is called out in a memorandum from the Assistant Secretary of Defense dated January 9, 2006. "The 95% dental readiness (Dental Class 1 or 2) target ensures that U.S.

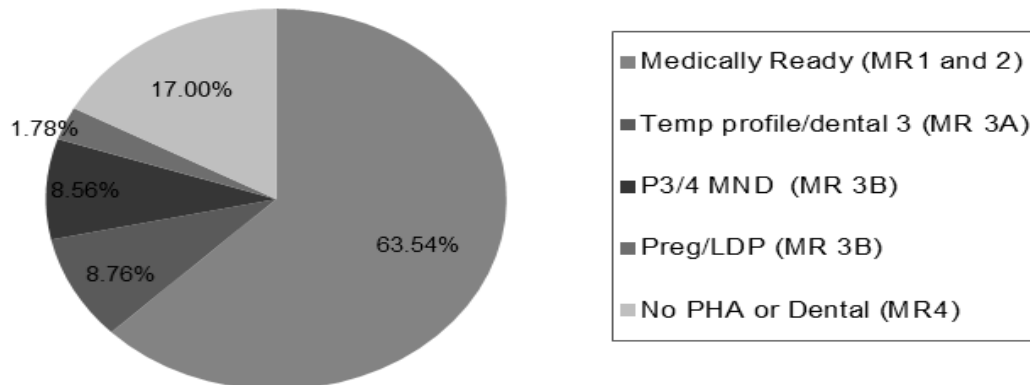
forces are maintaining an oral health status to support active duty deployability and Reserve activation.”³¹

In Figure 1 each of the eight MR categories are classified into five medical readiness categories based on the individual soldier’s level of compliance. These medical readiness categories are dynamic and change over the course of the year based on timing of medical requirements or appointments, condition of the soldier and the ability of unit administrators to input data. If a soldier was 100% in all categories listed above that soldier would be identified as an MR 1 or MR 2. Anything less than full medical readiness (that could not be obtained within 72 hours) would be considered a MR 3A, MR 3B or MR 4. Essentially, these categories provide commanders the ability to breakdown soldiers into groups or levels regarding the medical state of each soldier. MEDPRO’s provides the ability to aggregate this data in an effort to understand the total medical readiness of the force and to plan accordingly if not fully MR or in this case MR 1 or MR 2.

Current Metrics vs Goals

In June of 2010, United States Army Reserve Command (USARC) issued Operation Order 10-098 (US Army Reserve Command (USARC) 2010-2011 Medical Readiness Campaign) that spelled out the following mission statement: “USARC improves and sustains Soldier Medical Readiness Classification (MR) to 80% by 15JAN11, to meet Department of the Army’s published guidelines.”³² To date the USAR has not met the 80% MR, but has made great improvements in the last three years as depicted in Figure 2. A recent snapshot from MEDPROs indicates that the MR for the USAR is 63.54% (not including the Individual Ready Reserve-IRR). Figure 4 provides a

graphical view of the current medical readiness status of the USAR by each medical readiness category.



Source MEDPROS 25 Oct 2011, figures rounded, based on 182,177 Commander's Adjusted Strength

Figure 4: Current Medical Readiness Status of USAR by MR Category³³

It is clear from Figure 4 that there is still approximately 36% of the force that is not medically ready. After eliminating those soldiers in Basic Training, AIT, retirement groups etc, the commander's adjusted strength is 182,177 soldiers. Basic math tells us that 36% of 182k is approximately 65,000 soldiers which are not MR. By analyzing the 36% of non-MR soldiers in Figure 4 with the Medical Readiness categories described in Figure 1, there are some key categories that could be focused on with regards to improvement and priority of effort. If an assumption is made that there will always be a MR 3A (Temp profile/dental) and MR 3B (Preg/LDP) population due to the natural course of human life (sickness, injuries, pregnancies are inevitable) then the focus for analysis can shift to MR 3B P3/4 MND and MR 4 No PHA Dental categories.

First category for analysis is the MR 3B P3/4 status soldiers, which have medical requirements that cannot be resolved in 30 days-meaning they may have a profile, may

be pregnant or their temporary profile is greater than 30 days. There is also a concern that soldiers with temporary profiles may not be properly and timely classified based on their condition. The SMRC states: "When a commander identifies a Soldier with a permanent profile and who has reached his/her medical retention determination point, the Soldier may be processed through MOS/Medical Retention Board (MMRB) to determine if he/she meets retention standards. If a Soldier does not meet retention standards, then the Soldier will be referred to the Physical Disability Evaluation System (PDES) for a Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB)."³⁴ The P3 and P4 Profile MR 3B category is ripe for improvement from several angles as the system for validating and processing profiles in a timely manner has been an organizational concern for some time.

Figure 5 illustrates a snap shot of 6,049 P3 and P4 profiles that were screened by Rapid Evaluation Process (REP). The USAR Surgeons Office noticed through random review of profiles that the profiles did not meet the criteria for a P3/4 status, thus counting against the 8.56% P3/4 MND (MR 3B) category in Figure 4. A Six Sigma team was engaged to begin to understand the defect of incorrect profiles which resulted in the REP project being implemented. The data that is presented in Figure 5 is drawn from MEDPROs and although 6, 049 packets have been reviewed, there are still approximately 9,700 packets remaining and this number changes daily. The question of why profiles have been incorrectly designated as a P3/4 profile is best described by the USAR Command Surgeon:

The Army Reserves uses the Reserve Health Readiness Program contract for 100% of its Periodic Health Assessments but is not able to fully evaluate conditions identified, and relies on the Soldier providing information about their conditions to include documentation. In an effort

to avoid Soldiers showing up at the mobilization station and being Release from Active Duty (REFRAD) for medical reasons, the Army Reserve profiled based on the “best available” information at the PHA and erred on the side of caution in doing so. This resulted in a large number of Soldiers receiving permanent profiles who had not yet reached Medical Retention Determination Point. This LSS project was set up to notify the Soldier of the profile, determine if they have been medically evaluated for the condition, request or obtain additional information if available, and properly profile the Soldier. BOTTOM LINE: Not all P3/4 profiles in the Army Reserve can be presumed to require an MEB. Of the profiles reviewed 44% had either not reached Medical Retention Determination Point, or required a lower profile or none at all. 28% required a MAR2 and not an MEB. 17% elected to separate or retire, 6% with a non-duty related condition elected to have a PEB to determine fitness for continued service. Of the 6049 profiles reviewed 247 (4%) required an MEB (though we do expect this percentage to increase as we expand our profile review to more complex cases).³⁵

The 44% that the USAR Command Surgeon’s Office is describing are profiles from a sample group (Figure 5) that did not have valid criteria to qualify them as a P 3&4 profile. The USARC Surgeon’s office in conservative approach to identifying soldiers with possible P 3&4 profile conditions, when in reality the conditions or criteria used to screen the soldiers was not in fact a qualifying profile condition. Although 6,049 profiles have been reviewed, there are still approximately 9,700 that have not been screened. The basis for the profile screening was using the PULHES coding found on every U.S. Army soldiers medical records. PULHES categories are defined as (P) Physical, (U) Upper, (L) Lower, (H) Hearing, (E) Eyes and (S) Psychiatric. AR 40-501 Standards of Medical Fitness define the individual scores of each PULHES factors as follows:

Four numerical designations are assigned for evaluating the individual’s functional capacity in each of the six factors. Guidance for assigning numerical designators is contained in table 7–1. The numerical designator is not an automatic indicator of “deployability” or assignment restrictions, or referral to an MEB. The conditions listed in chapter 3 and the Soldier’s functional limitations, rather than the numerical designator of the profile, will be the determining factors for MEB processing.

- (1) An individual having a numerical designation of “1” under all factors is considered to possess a high level of medical fitness.
- (2) A physical profile designator of “2” under any or all factors indicates that an individual possesses some medical condition or physical defect that may require some activity limitations.
- (3) A profile containing one or more numerical designators of “3” signifies that the individual has one or more medical conditions or physical defects that may require significant limitations. The individual should receive assignments commensurate with his or her physical capability for military duty.
- (4) A profile serial containing one or more numerical designators of “4” indicates that the individual has one or more medical conditions or physical defects of such severity that performance of military duty must be drastically limited.³⁶

It is the PULHES factors above that the Lean Six Sigma (LSS) team used to begin screening the profiles illustrated in Figure 5. The PULHES factors are a more specific level of detail regarding a soldier’s individual medical readiness or MR. As the Command Surgeon indicates, the LSS (Lean Six Sigma) Team used a code of 3 or 4 in only one category of the PULHES system for initial screening. By limiting the first screen of the profiles to only one category, the LSS team was able to eliminate the potentially least complex medical profiles-which means less analysis to determine if the profile was indeed unqualified. Profiles with 3 or 4 scores in two or more PULHES categories have been slated for review but are more likely to be a qualified or substantiated profile.

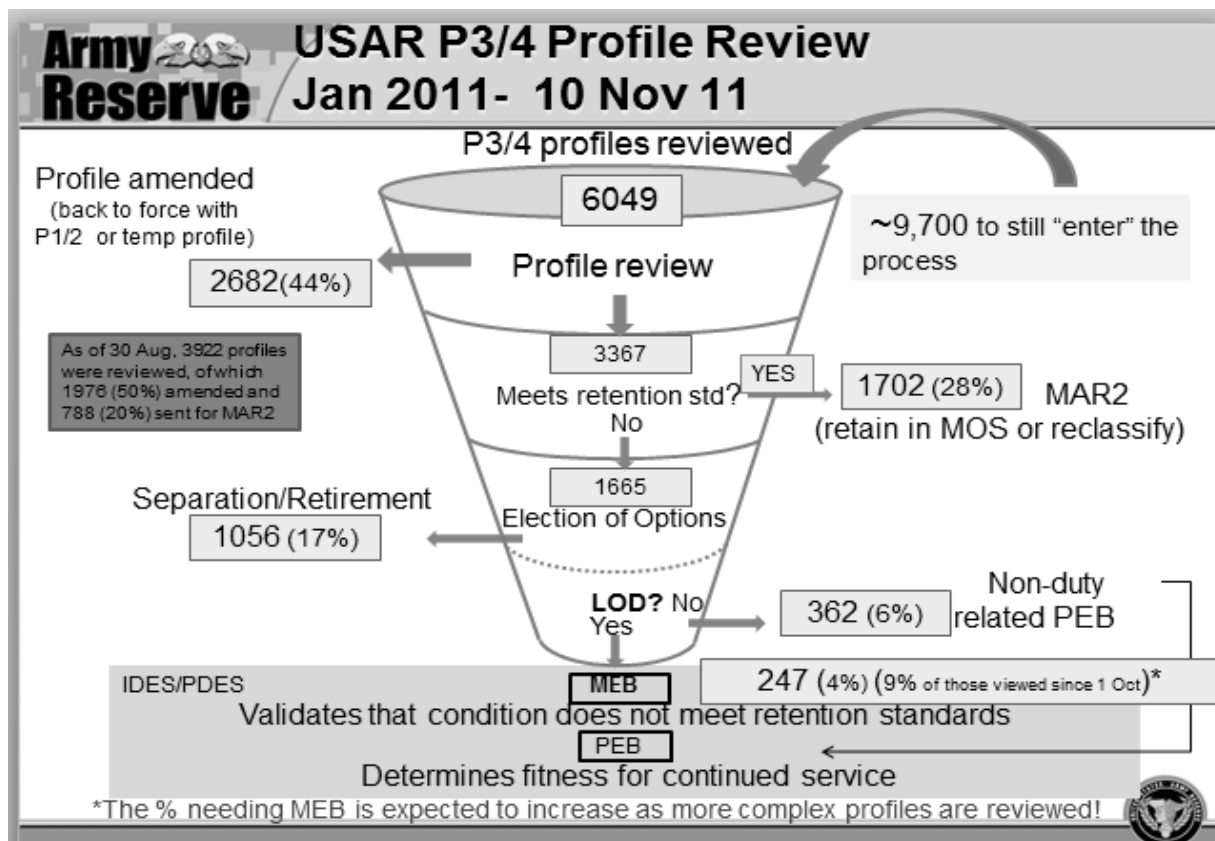


Figure 5: USAR P3 and P4 Profiles, November 2011³⁷

The second category for analysis is the MR4, No PHA or Dental population. If we refer back to Figure 1, the chart identifies MR 4 as status unknown, which translates to missing or incomplete Periodic Health Assessment data or dental screening data. There may be many reasons for gaps of information in this category, which can include delayed processing of paperwork from the medical or dental provider to missing or not completing appointments for PHA's or dental screening. At 17%, MR 4 accounts for approximately 31,000 soldiers, a staggering number. To put the MR 4 population into perspective, if all 17,000 soldiers met the required appointments or missing information and we added in the 63,000 MR ready soldiers (as 25 Oct 11) the USAR would meet the 80% MR goal. The M4 population has the greatest potential payback in terms of readiness, if addressed and resolved.

Recommendations

The purpose of the following recommendations is to identify fiscal and operational opportunities in aggregate that indicate areas for improvement. Some of these recommendations such as one, two and four will require further analysis and study to determine the exact benefit and operational impact. Specifically, the following four recommendations will focus on the two USAR medically not ready populations identified in the analysis; P3&4 (MR 3B) and No PHA or Dental (MR4). If current trends hold, correction of these populations by little more than a 50% reduction would place the USAR at 80% medical readiness and meet the defined DoD goal.

Create a Medical Funding Pool. The current USAR medical system will only diagnosis medical problems and will not fix them unless they are in the line of duty (LOD). The basis of this recommendation is for the USAR to pay for certain medical injuries that are not LOD with the benefit of increased medical readiness and cost savings through retention of trained and experienced soldiers. Currently, the USAR will allocate money to fix dental problems in addition to the annual dental exams provided.³⁸ According to the Office of the Chief Army Reserve (OCAR), there is \$43.9M in FY12 allocated for dental treatment, yet there is no money for medical treatment unless in the line of duty.³⁹ The potential soldier population that would require treatment outside of the LOD rules could be very significant. During the research of this paper, there have been no identified studies which explore the impact to costing or medical readiness by paying for medical treatment. Conventional wisdom however, would point to two populations of soldiers that could benefit from medical treatment and remain in the USAR, in their respective MOS.

The two potential populations that could be the primary target of medical treatment can be referenced in Figure 5. The MAR2 and Non-duty related PEB populations indicated in Figure 5 represent approximately 2,064 soldiers (1,702 MAR2 plus 362 Non-duty PEB) or 34% of the P3/4 profile population presented in the diagram. With a fair degree of certainty, the entire population of 2,064 identified soldiers will not require medical treatment, but it is highly probable that most will. A further study and analysis would have to be conducted to better understand the exact ratio of soldiers requiring treatment vs. those that do not.

In addition to the potential medical readiness increase of 34% within the P3/4 population there is also a potential significant cost savings. Figure 6 depicts the USAR soldier costs for FY09 and FY10. The costs in Figure 6 are the annual rates for a Troop Program Unit Soldier (TPU) or a traditional reserve status soldier. If the total annual cost per soldier (FY10) is \$26.9k and we multiply 2,064 potentially treatable and retainable soldiers by the FY10 rate, the USAR in effect could lose approximately \$55M that the United States tax payer has invested- just on an annual basis. A further consideration in this formula would be the average tenure of a USAR soldier which would significantly compound the human capital investment loss. Most USAR soldiers are senior in rank (Staff Sergeant and above) and have an average of ten years of service.⁴⁰ If we multiplied the \$55M by ten (representing ten years) the potential investment loss is a staggering \$557M. The \$557M loss does not consider the \$75k per soldier initial entry cost which could further increase the loss. A detailed study and analysis of this recommendation would need to be performed.

Category	FY09	FY10
Compensation Costs per Soldier		
Total Part-Time Pay and Allowances	\$8,569	\$10,506
Retiree Pay Accrual - Part-Time	\$1,343	\$1,746
Medicare Healthcare Accrual - Part-Time	\$3,222	\$3,194
Incentive Programs	\$2,605	\$2,038
Total Compensation Costs per Soldier	\$15,739	\$17,483
Operations and Maintenance Costs per Soldier		
Recruiting Operations	\$288	\$287
RC Medical Readiness	\$448	\$488
Land Force Unit Support	\$7,103	\$6,362
Land Force Readiness	\$184	\$157
Land Force Readiness Support	\$3,235	\$2,209
Total Installation and Training Costs per Soldier	\$11,259	\$9,503
Total Cost per soldier	\$26,997	\$26,987

Figure 6: USAR Annual TPU Soldier Costs for FY09 and FY10⁴¹

Move to a Bi-Annual PHA. If there are approximately 182,000 USAR members (commanders adjusted strength-not including the IRR), that are regulated by Title 10 USC 10206, then there are an equal number of PHA's required annually. As we have seen (see Figure 3), the ARFORGEN model is a five year model with USAR members split into four force pools. Only one of these pools (the Enabler Force) provides an enabler force for mobilization commitments. If the priority were given to this group of soldiers for an annual PHA and the other three force pools were given a bi annual requirement, the reduction in non-medically ready soldiers could be two fold. First, 24,000 (actual requirements may be higher to anticipate loss or attrition) soldiers would require annual appointments and scheduling the remaining 158,000 would not. The remaining 158,000 USAR soldiers could go to a bi-annual commitment for both medical and dental. Tracking, paying and ensuring soldiers get to PHA or dental appointments would be cut in half. If 17% of the force has no dental or PHA on record and half of those had more time to meet appointments, it is possible that missed appointments

would decline. Arguably, understanding how time would equate to a decrease in missed appointments would have to be studied. This recommendation would require a change to Title 10 USC 10206 from an annual to a bi-annual PHA for reserve components.

From a cost perspective, there are two groups of soldiers that would require an annual PHA and dental exam; the remaining would be bi-annual. The first group requiring an annual (PHA and dental) exam would be the 24k Enabler force and the second would be half of the remaining USAR population or one half of the 158,000 which equates to about 79,000 soldiers. The current approximate costs for a PHA is \$717.00 and \$211.00 for a dental exam.⁴² Under current policy there are approximately 182,000 members that require a PHA or approximately \$130M ($\$717.00 \times 182k$) and \$38.4M ($\$211.00 \times 182k$) for dental in cost to the American public. It is evident that if the biannual PHA and dental split option would be implemented, there could be a significant cost savings or reallocation of financial resources to preventive or treatment of problems diagnosed during the exams. From a savings perspective there would be 79,000 less annual PHA and Dental exams, which would equate to approximate savings of \$72.6M annually (\$56M for PHA's and \$16.6M for dental exams).

The \$72.6M is for screening exams only-whether PHA or Dental. There is no funding included to complete an additional diagnostic evaluation of Soldiers who report medical conditions that did not occur in the line of duty.⁴³ Additionally, there is no funding for treatment of non-duty related injuries. With additional screening or treatment dollars in the budget for non-duty related injuries USAR soldiers unlike their active component peers do not have the means to treat medical problems unless they carry

private insurance or have private funding. If PHA and dental exams are cut to a bi-annual basis it may be possible to utilize the \$72.6M savings to provide treatment or provide a pay stipend for TriCare insurance that would be used by the service member to treat these non-duty related injuries or disease. As mentioned previously, a detailed feasibility and cost analysis would need to be conducted in order to fully understand the fiscal benefit and operational impact.

In addition to the bi-annual exam savings, there are also several other savings that would need to be reviewed and studied by reducing the annual volume of medical or dental appointments. The first area of study would be the reduction of appointments and administration services rendered by private vendor contracts under the Reserve Health Readiness Program (RHRP). A second area would be reduction of pay or RMA's paid to reservists who attend screening appointments. If fewer soldiers are required to make appointments, there will be a smaller pay commitment as most screening appointments are paid blocks of duty. A third area of savings would be the time and effort spent by Active Guard and Reserve (AGR) and unit administrators tracking and managing appointments. The time spent by the unit full time staff whether AGR or full time DoD employees to track and ensure soldiers meet readiness guidelines could be better utilized in managing others areas for the command.

Commanders Medical and Dental Policy. Clearly there needs to be improvement and emphasis by commands from the company or detachment level up in enforcing medical and dental compliance of soldiers. In December of 2011, the CAR issued a memorandum detailing how to handle MNR soldiers.⁴⁴ This memorandum essentially explains that enforcement of medical standards is to be handled by the individual

subordinate commands. Unfortunately, the memo issued by the CAR does not provide much detail regarding the enforcement of medical regulations or compliance. As noted earlier, there are several regulations and guidelines that are published which dictate readiness goals and levels. Where these published requirements have excelled in outlining metrics for successful readiness, they have lagged in the soldier's accountability and responsibility in meeting these goals.

There are two primary areas in which soldiers fail to meet medical and dental readiness. The first is not making, meeting or multiple rescheduling of appointments for dental and medical screening. Soldiers who fail to meet appointments for any reason push the ability of commands to meet annual requirements and also fall short of being medically fit a timely manner according to published guidelines and directives. The second shortfall of individual soldiers is medical documentation or identification of medical conditions that may be duty or deployment limiting. Soldiers who fail to inform the proper medical personnel with known changes in personal health delay unit and individual readiness and the ability of the USAR to act accordingly to address the individual condition. Discovering known health related issues at the mobilization station, instead of being addressed earlier causes operational and readiness delays that are unnecessary.

Certain individual commands have identified the soldier responsibility gap and enacted directives based on legal guidance from JAG. These memorandums specifically call out published guidelines, soldier individual responsibility and penalties for not meeting those guidelines. Like any other law or directive published, the effectiveness of the directive is only as good as the enforcement and emphasis of the

command. If soldiers are not going to be held accountable, medical and dental goals and metrics will suffer. A sample directive enforcing the soldier accountability gap is illustrated in Appendix A.

Better Utilization of the Reserve Component- Soldier Medical Support Center (RC-SMSC). The RC-SMSC is a relatively new organization that is spelled out in the Soldier Medical Readiness Campaign Plan 2011-2016. Currently this organization provides quality assurance or assistance for Medical Evaluation Board (MEB) packets identified and received from USAR Regional Support Commands (RSC). Soldiers that require a MEB fall clearly into the P3/4 MND (MR 3B), No PHA or Dental (MR4) and possible MR 3A categories as described earlier. Leveraging the institutional knowledge of the RC-SMC in a more proactive and productive manner will provide for quicker resolution of soldiers who require a MEB. Figure 7 outlines the process through which a soldier with a condition requiring a medical board is processed.

In order to reduce the MR 3B and MR 4 categories with better speed and efficiency, the RC-SMSC should broaden their service and support capabilities by not only identifying defects in MEB packets, but also by providing the capability of processing MEB packets from the beginning with the RSC. Instead the RSC of waiting for the defect scan and list corrections provided by the RC-SMSC, the RC-SMSC can provide a greater processing capability by actually building the MEB packet with the RSC and taking some of the operational and administrative manpower strain off the RSC. By having a more integrated and active support role the rework of MEB packets and speed with which soldiers are retained, separated or identified for LDP's would be greatly reduced. Understandably, studies and process simulations would need to be

implemented to determine the exact effect, organizational impact and precise allocation of resources from both the RSC and RC-SMSC.

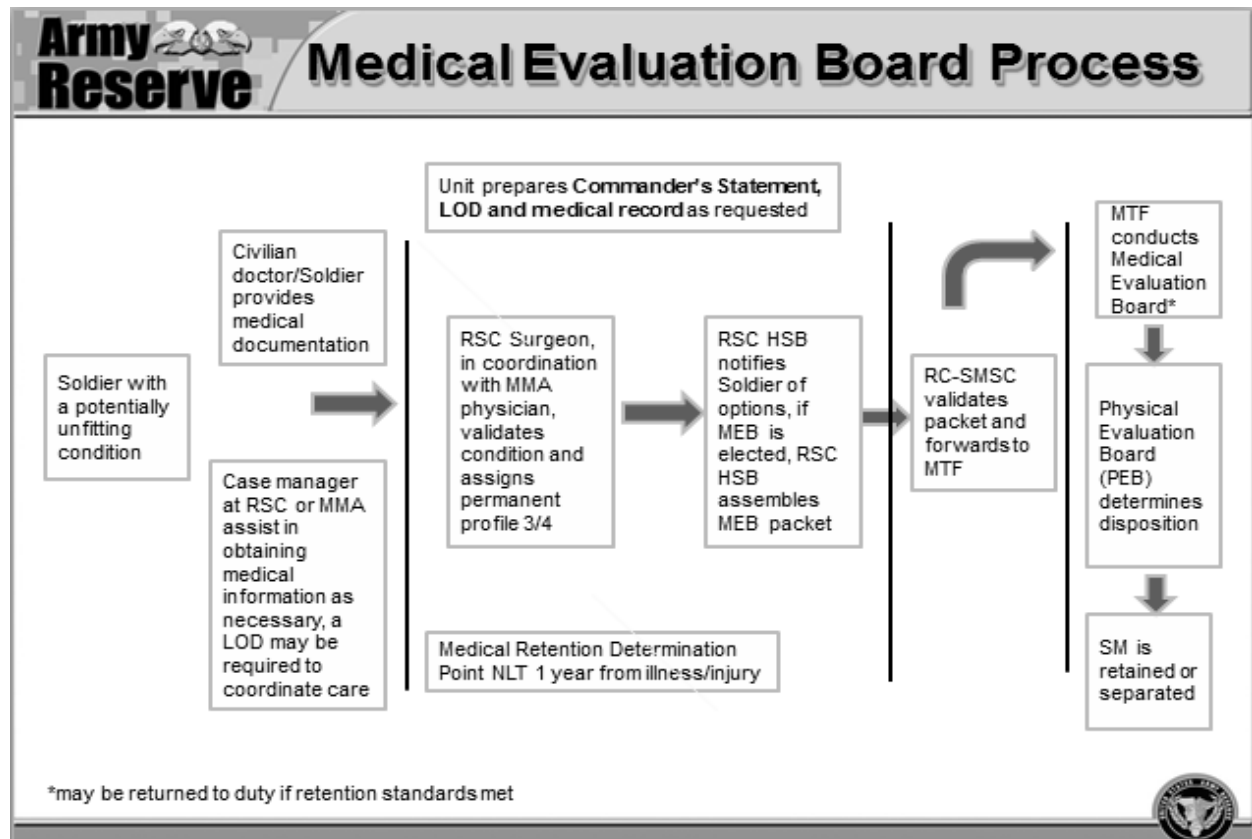


Figure 7. Medical Evaluation Board Process⁴⁵

Conclusion

Significantly reducing the MR 3B and MR 4 medical categories to meet DoD medical readiness guidelines will require a multi-pronged approach. As stated many times in this paper, an Operational Reserve is desired by all levels of the active and reserve components. In order to maintain the newly minted operational reserve a more refined, multipronged approach is required. First, funding regulations and allocations for PHA examinations need to transition from purely a diagnosis focus, to a joint diagnosis

and medical treatment solution. Second, a more stringent set of rules and penalties need to be established and enforced to ensure compliance by the individual soldier. Soldier accountability for their own health readiness must be addressed in a more aggressive manner. Lastly, a more comprehensive utilization of active component medical organizations to screen medical packets for defects and faster processing of soldiers with identified medical shortcomings will enable the reserve to expeditiously retain or separate soldiers. Without doubt, the solutions provided in the paper will reduce the MNR population, reduce costs, and most importantly provide the active component with the reserve soldiers required to sustain current and future operations.

Endnotes

¹ LTG Jack C. Stultz and CSM Michael D. Schultz, The United States Army Reserve 2011 Posture Statement, Fiscal Year 2011, Posture Statement presented to the 112th Congress, 1st sess. (Washington, DC: US Army Reserve Command, 2011), ii.

² Ibid., 14.

³ Chapman, Dennis P., *Manning Reserve Component Units for Mobilization: Army and Air Force Practice* (The Institute of Land Warfare: Association of the United States Army) 2009, 3.

⁴ Office of the Surgeon General and Commanding General, USAMEDCOM, *Medical Readiness Leader Guide Ver. 1.0*, (Falls Church, VA: Office of the Surgeon General, 2011), 16.

⁵ COL Sharon McKiernan MD, USAR Command Surgeon, interview by author, January 2012.

⁶ Office of the Under Secretary of Defense for Personnel and Readiness, *Strategic Plan for Fiscal Years 2010-2012*, (Washington, DC: US Government Printing Office, December 30, 2009), 7.

⁷ Goals provided by the USARC Surgeons Office in email dated 14NOV11.

⁸ LTC John Eddy, *Towards and Operational Force: Health Readiness in the Army Reserve*, Strategy Research Project (Carlisle Barracks, PA: U.S. Army War College, March 2010), 10.

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¹⁰ Jim Hinnant, "Rodriguez speaks at AUSA breakfast", Paraglide, October 13, 2011.

¹¹ LTG Jack C. Stultz and CSM Michael D. Schultz, The United States Army Reserve 2011 Posture Statement, Fiscal Year 2011, Posture Statement presented to the 112th Congress, 1st sess. (Washington, DC: US Army Reserve Command, 2011), 4.

¹² U.S. Army Medical Command, *Solider Medical Readiness Campaign Plan 2011-2016*, (version 1.2, May 2011), 3.

¹³ Ibid., 3.

¹⁴ Ibid.

¹⁵ Ibid., 5.

¹⁶ Ibid., 13.

¹⁷ Ibid.

¹⁸ Ibid., 14.

¹⁹ Ibid.

²⁰ LTG Jack C. Stultz and CSM Michael D. Schultz, The United States Army Reserve 2011 Posture Statement, Fiscal Year 2011, Posture Statement presented to the 112th Congress, 1st sess. (Washington, DC: US Army Reserve Command, 2011), 3.

²¹ LTG General Jack C. Stultz, Chief Army Reserve and Commanding General, US Army Reserve Command, *Army Reserve Vision and Strategy 2020*, (Ft McPherson, GA: USARC, 2011), 7.

²² Department of Defense Directive, Managing the Reserve Components as an Operational Force, Number 1200.17, (Washington, DC: Department of Defense, October 29, 2008), 4.

²³ Ibid., 4.

²⁴ Ibid., 7.

²⁵ Department of Defense Instruction, Individual Medical Readiness (IMR), Number 6025.19, (Washington, DC: Department of Defense, January 3, 2006), 3.

²⁶ Office of the Under Secretary of Defense for Personnel and Readiness, *Strategic Plan for Fiscal Years 2010-2012*, (Washington, DC: US Government Printing Office, December 30, 2009), 7.

²⁷ Office of the Under Secretary of Defense for Personnel and Readiness, *Fiscal Year 2012-2016 Strategic Plan*, (Washington, DC: US Government Printing Office, February, 2011), 1.

²⁸ Ibid., 3.

²⁹ Office of the Under Secretary of Defense for Personnel and Readiness, *Fiscal Year 2012-2016 Strategic Plan*, (Washington, DC: US Government Printing Office, February, 2011), 4.

³⁰ Department of Defense Instruction, Individual Medical Readiness (IMR), Number 6025.19, (Washington, DC: Department of Defense, January 3, 2006), 8.

³¹ U.S. Assistant Secretary of Defense William Winkenwerder, "Policy on Oral Health and Readiness," memorandum for the Assistant Secretaries of the Military Departments, Washington, DC, January 9, 2006.

³² BG Jeffery Buchanan, USARC G3/5/7, "Operation Order 10-098 (US Army Reserve Command (USARC) 2010-2011 Medical Readiness Campaign)", Fort McPherson, GA, US Army Reserve Command, June 25, 2010.

³³ Chart and Data provided by USAR Command Surgeons Office, October, 2011.

³⁴ U.S. Army Medical Command, Solider Medical Readiness Campaign Plan 2011-2016, (version 1.2, May 2011), 12.

³⁵ COL Sharon McKiernan MD, USAR Command Surgeon, interview by author, November 2011.

³⁶ U.S. Department of The Army, *Standards of Medical Fitness*, Army Regulation 40-501(Washington, DC: U.S. Department of the Army, August 23, 2010), 75.

³⁷ Figure provided by the USAR Command Surgeons Office, October,2011.

³⁸ Information provided by LTC Dennis Ratliff, Sr., Senior Medical Analyst, Office of the Chief Army Reserve, February, 2012.

³⁹ Figure provided by LTC Dennis Ratliff, Sr., Senior Medical Analyst, Office of the Chief Army Reserve, February, 2012.

⁴⁰ Figure provided by LTC Dennis Ratliff, Sr., Senior Medical Analyst, Office of the Chief Army Reserve, February, 2012.

⁴¹ Table provided by LTC Dennis Ratliff, Sr., Senior Medical Analyst, Office of the Chief Army Reserve, February, 2012.

⁴² Data provided by the USAR Command Surgeons Office, November,2011.

⁴³ Information provided by the USAR Command Surgeons Office, November,2011.

⁴⁴ Chief United States Army Reserve LTG Jack Stultz, "Administrative Options for Medically Non-Ready and Non-Compliant Soldiers", memorandum for USAR Major Subordinate Commands, December 12, 2011.

⁴⁵ Figure provided by the USAR Command Surgeons Office, November, 2011.

Appendix A

MEMORANDUM FOR

SUBJECT: Direct Order to Receive Required Medical, Dental and Immunization Services

1. References:

- a. AR 40-562, Immunization and Chemoprophylaxis, 29 September 2006, paragraph 3-1.h. and Appendix D.
- b. Operation Order 09-75, Headquarters, U.S. Army Medical Command, 251900Q September 2009, Novel A (H1N1) Influenza Vaccine Immunization Program, paragraphs

2., 3. And 3.e.(5)(b).

- c. Fragmentary Order 6 to Operation Order 09-76, Headquarters, U.S. Army Medical Command, 171745Q March 2010, Novel A (H1N1) Influenza Vaccine Immunization Program, paragraph 1.d.

2. You are receiving this memorandum because you have failed to receive required medical and/or dental services. You will be held accountable for your compliance with this direct order to receive Periodic Health Assessment (PHA) / DENTAL / IMMUNO service(s) and turn in your service received voucher as described in paragraph 4. You must receive your required medical and/or dental services not later than XXXXXX.

3. For any of the services you need, you must contact Logistics Health at (800) 666-2833, Monday through Friday from 0700 to 2200, Central Standard Time (CST) and Saturday from 0700 to 1500 (CST). When you contact Logistics Health for any appointment you can request services from a provider as close to you as possible as well as attempt to receive an appointment in the evening or on a Saturday or Sunday. While it is our policy to allow you to attend this appointment in an IDT (RMA) status for pay purposes, we can also make arrangements for you to be issued "AT" orders instead should a weekday appointment present a conflict with your employment and where your employer requires that you have an "AT" order in lieu of IDT (RMA), but it is incumbent upon you to contact the Unit Administrator (XXXXXXX) to request such orders immediately after setting your appointment should you desire "AT" orders in lieu of IDT.

a. If you require a PHA, the first step is to complete an online survey through AKO. Log into AKO and once you reach the AKO Home Page, go to the right side of the screen and left click once on "My Medical Readiness Status." Once you reach the medical readiness screen, on the left hand side under the "Medical Readiness Tools" heading, left click once on the "Periodic Health Assessment (PHA)" heading printed in the orange highlighted bar. Follow the instructions for completing your portion of the PHA online then contact Logistics Health to schedule your appointment.

b. If you require dental and/or immunization services you only need to contact Logistics Health as there is no initial online form to complete.

4. Prior to leaving the service provider, ensure you have the voucher that certifies you received the services and that it is signed and dated by the provider and you. Within 72 hours after your appointment, you must submit that voucher to the S1 office either by calling ahead and notifying XXXXXXXX at XXX-XXX-XXXX and then faxing the signed voucher to XXX-XXX-XXXX or scanning and e-mailing to the S1 e-mail account at XXXXXXXX.

5. If you are informed at your appointment that you require follow-up services, you must contact XXXXX so that he can authorize follow-up treatment. Subsequently, Logistics Health will contact you for your next appointment.

6. Soldiers failing to follow this order to have the above service(s) completed will be in violation of the Uniform Code of Military Justice, including but not limited to Article 92, Failure to Follow a Direct Order. While every effort has been and will be made to provide accommodation and to ensure your compliance with this order, as set forth in the paragraphs above, the consequences of failing to comply with this order and to ensure your continued medical readiness and deployability can include adverse administrative and/or disciplinary action up to and including processing for discharge from the Army Reserve.

//Original Signed//